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# Access Denied: Assisted Reproductive Technology Services and the Resurrection of Hill-Burton

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## ACCESS DENIED: ASSISTED REPRODUCTIVE TECHNOLOGY SERVICES AND THE RESURRECTION OF HILL-BURTON

Susan B. Apel<sup>†</sup>

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### I. INTRODUCTION

Access to assisted reproductive technologies (ART) remains largely unregulated. While some federal and state laws and professional guidelines may prevent or discourage certain kinds of discrimination, health care providers can and do withhold services from prospective patients for many reasons. Most recently, as reported in *North Coast Women's Care Medical Group, Inc. v. San Diego County Superior Court*, Guadalupe Benitez was refused ART services because she was unmarried and a lesbian.<sup>1</sup> Surveys of fertility clinics in the United States show that this kind of discrimination is not unusual.

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1. 189 P.3d 959 (Cal. 2008).

The Hospital Survey and Construction Act, commonly known as the Hill-Burton Act or Hill-Burton Program, was enacted in 1946.<sup>2</sup> Its purpose was to make federal funds available to communities across the nation “to furnish adequate hospital, clinic or similar services to all their people.”<sup>3</sup> Facilities that received Hill-Burton funds were required to 1) ensure that services were provided to all members of the community, and 2) provide a certain amount of free medical services to those in need.<sup>4</sup>

This article explores the question of whether or not the Hill-Burton Act may be used by those persons, like Ms. Benitez, who are denied access to assisted reproductive technologies for non-medical reasons, such as marital status or sexual orientation. After documenting the discriminatory treatment of potential ART patients, and then looking at the history and language of the Act along with judicial interpretations thereof, I conclude that Hill-Burton may provide a tool to challenge discrimination in provision of ART services.

## II. ART: ACCESS DENIED

Assisted reproductive technologies are being used by increasing numbers of people for whom such technologies represent their best—and in most cases, only—means of having a child. Since 1981, more than 177,000 infants have been born through the use of ART; in the year 2000, 100,000 cycles of ART were attempted.<sup>5</sup> The provision of these services has raised numerous ethical and social issues, including the question of whether or not ART should be available to all who request it, or whether certain persons, or persons with certain characteristics, should be excluded. One study calls this phenomenon an “access to services” issue, defined as a “dilemma caused by the presence of behaviors or conditions in the patient that the provider finds to be so problematic for ethical or other reasons that the provider is uncomfortable treating this individual.”<sup>6</sup> Some providers of ART

2. Pub. L. No. 79-725, 60 Stat. 1041 (1946) (codified as amended at 42 U.S.C. §§ 291–291m). The Hill-Burton Program was updated in 1975. Pub. L. No. 93-641, 88 Stat. 2268 (1975) (codified as amended at 42 U.S.C. §§ 300q–300t).

3. 42 U.S.C. § 291 (2000).

4. National Health Law Project, *A Hill-Burton Primer*, 19 CLEARINGHOUSE REV. 13, 13 (1985).

5. Andrea D. Gurmankin et al., *Screening Practices and Beliefs of Assisted Reproductive Technology Programs*, 83 FERTILITY & STERILITY 61, 61 (2005).

6. Judy E. Stern et al., *Access to Services at Assisted Reproductive Technology*

services have established policies that prohibit their use by single persons or same-sex couples.<sup>7</sup> Other providers may be less specific and less direct, opting to judge individuals seeking their help on a case by case basis. In some cases, “the welfare of the child” may be a dispositive factor in the decision to offer or withhold treatment. This means that an individual provider can and does weigh many aspects of a prospective patient, which include judgments about his or her potential parenting abilities.<sup>8</sup> In one survey, 64% of ART program directors stated their belief that it is their responsibility to consider the parents’ fitness before helping them to conceive.<sup>9</sup>

The nature of this access to services issue may be peculiar to assisted reproductive technologies as opposed to other more routine kinds of medical care. Refusal to provide treatment may spring from the unique characteristic of this kind of medical service; that is, that the result of the treatment, if successful, is a child. Thus, providers of this service may feel a responsibility not just to the potential patient but to the resulting child as well. In an instance when a physician may think that a potential patient would not be a “good” parent because she is single, or lesbian, or overweight, or too poor, the physician may experience a conflict between wanting to serve a patient’s needs and what he or she perceives as the welfare of the child. This may be appropriate in some cases. The problem is trying to define those instances in which concerns about a patient’s lifestyle and life conditions are legitimate enough to override a right to reproduce, and those instances that constitute improper and possibly illegal discrimination against the patient. One commentator states: “[w]ell-intended efforts to prevent the birth of a baby to a parent with a known history of violence against children could perhaps slide into discriminatory or eugenic practices to prevent those who are poor, who follow nonmainstream lifestyles, or who are

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*Clinics: A Survey of Policies and Practices*, 188:4 AM. J. OBSTET. GYNECOL. 591, 591 (2001).

7. *Id.* at 596 (showing that only 79% of clinics surveyed treat single women and 74% treat lesbian couples). *See also* Gurmankin, *supra* note 5, at 66 tbl.7 (showing that 10% of clinics surveyed were “very or extremely likely” to turn away single women and 50% to turn away single men; 17% were “very or extremely likely” to turn away lesbian couples and 48% to turn away gay male couples).

8. *See generally* Ethics Committee of the American Society for Reproductive Medicine, *Child-Rearing Ability and the Provision of Fertility Services*, 82 FERTILITY & STERILITY 564 (2004).

9. Gurmankin, *supra* note 5, at 63.

members of a racial minority from having children.”<sup>10</sup>

The facts in the recent case of *Guadalupe Benitez* exemplify, although they do not exhaust, the nature of and reasons behind these kinds of treatment decisions.<sup>11</sup> Ms. Benitez sought assisted reproductive services at North Coast Women’s Care Medical Group in San Diego County.<sup>12</sup> Benitez had attempted self-insemination without success and was diagnosed and referred to North Coast for treatment for polycystic ovarian syndrome.<sup>13</sup> During a visit with one provider, Dr. Brody, Benitez mentioned that she was a lesbian.<sup>14</sup> The provider reportedly told Benitez that if intrauterine insemination (IUI) proved necessary, she (the provider) could not participate, as her religious convictions prevented her from performing ART procedures on unmarried women.<sup>15</sup> She also said that her colleague, Dr. Fenton, had similar beliefs but that two other physicians in the practice would be available to assist Benitez.<sup>16</sup> When further attempts at self-insemination did not produce a pregnancy, Benitez opted for the IUI procedure, using the fresh sperm of a friend.<sup>17</sup> Dr. Brody informed her that North Coast had to consult its own protocols on use of fresh sperm from a non-husband.<sup>18</sup> Benitez then decided to forgo the fresh sperm in favor of sperm from a sperm bank.<sup>19</sup> Dr. Brody then went on vacation, leaving the care of Benitez to Dr. Fenton.<sup>20</sup>

There was confusion as to Benitez’s decision to use sperm from a sperm bank, and Dr. Fenton believed that she still wanted to use the fresh sperm from the known donor.<sup>21</sup> This posed problems, as only Dr. Fenton was licensed to perform this kind of procedure.<sup>22</sup> But he too, like Dr. Brody, had religious objections, and the remaining physicians did not possess the necessary

10. *Id.* at 62.

11. *See* *N. Coast Women’s Care Med. Group, Inc. v. Superior Court*, 189 P.3d 959 (Cal. 2008).

12. *Id.* at 963.

13. *Id.*

14. *Id.*

15. *Id.* Apparently Dr. Brody was willing to provide some care to Ms. Benitez, but drew the line at this particular procedure.

16. *Id.*

17. *Id.* at 964.

18. *Id.*

19. *Id.*

20. *Id.*

21. *Id.*

22. *Id.*

expertise.<sup>23</sup> Benitez was therefore referred to a provider outside of the North Coast practice.<sup>24</sup>

Benitez filed an action against the physicians and North Coast, claiming sexual orientation discrimination in violation of California's Unruh Civil Rights Act.<sup>25</sup> Defendants responded that they were exercising their rights to freedom of religious expression under the First Amendment. The California Supreme Court ultimately held against Defendants on the First Amendment argument; whether the case continues remains to be seen, as Defendants now wish to assert that the basis of discrimination was marital status, not sexual orientation. Marital status, apparently, is not covered by the Unruh Act.<sup>26</sup>

Constraints on the ability of ART providers to refuse services exist in some form, but are relatively weak. Generally speaking, and with the exception of emergency treatment, physicians are not required to treat all patients who seek their services. Some state laws that prohibit discrimination on the basis of marital status and sexual orientation exist, but they are spotty in the sense that many states have no such legislation and those that do vary in the kinds of discrimination they prohibit and to which kinds of entities they apply.<sup>27</sup> As for professional self-regulation, the American Medical Association has issued a resolution that healthcare providers should not discriminate on the basis of sexual orientation in the provision of health care.<sup>28</sup> The American Society for Reproductive Medicine

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23. *Id.*

24. It is important to note that issues of access cannot always be resolved by referral to another facility. In the *North Coast* case, North Coast was the only OB-GYN provider in Ms. Benitez's health insurance plan. Therefore she had no choice other than North Coast, and her subsequent treatment and pregnancy had to be paid out-of-pocket. Lambda Legal, *Benitez v. North Coast Women's Care Medical Group* (Q & A) (June 22, 2005), <http://www.lambdalegal.org/our-work/publications/facts-backgrounds/page.jsp?itemID=31987395>.

25. CAL. CIV. CODE § 51 (West 2006).

26. *Id.* The Act provides that "[a]ll persons within the jurisdiction of this state are free and equal, and no matter what their sex, race, color, religion, ancestry, national origin, disability, [or] medical condition." *Id.* The act had been construed to include sexual orientation and was formally amended to include this in 2005. *Id.*

27. Susan B. Apel, *Access to Assisted Reproductive Technologies*, 12 J. MED. & L. 33, 37-41 (2008) (discussing state law conscience clauses and recent attempted legislation on this issue); Robin Fretwell Wilson, *The Limits of Conscience: Moral Clashes Over Deeply Divisive Healthcare Procedures*, 34 AM. J.L. & MED. 41, 50-52 (discussing state law conscience clauses).

28. See AM. MED. ASS'N, GBLT POLICY COMPENDIUM 1 (Sept. 2005),

(ASRM) along with its affiliate organization, the Society for Assisted Reproductive Technology (SART), frowns upon discrimination against same-sex individuals and single people.<sup>29</sup> It does, however, uphold the ability of providers to make decisions about access based upon the providers' judgments regarding the welfare of the potential child.<sup>30</sup> The positions that ASRM has taken are in the form of ethics committee reports, which are advisory in nature and for which there are no effective enforcement mechanisms.

To return to Benitez and for purposes of this analysis, the legal procedures and conclusions in this case may be less relevant than the facts. The facts are that the fertility clinic turned Benitez away, either because she was single or because she was a lesbian.<sup>31</sup> If the latter, Benitez had the good fortune to live in a state that includes sexual orientation in its state anti-discrimination legislation. If the former, Benitez may be without legal recourse under state law. And those patients who are refused service for reasons less categorical than marital status or sexual orientation—who, for example, have been deemed less than ideal potential parents—may have the least protection of all under any existing law.

### III. THE HILL-BURTON ACT: HISTORY AND EXPLANATION

In 1946, Congress enacted the Hospital Survey and Construction Act, popularly called the Hill-Burton Act or Hill-Burton Program.<sup>32</sup> The Act was passed in response to a perceived shortage of hospitals throughout the nation.<sup>33</sup> The Act made federal funds available for construction of hospitals and other medical facilities.<sup>34</sup> The Hill-Burton Program “was not intended only to provide funding construction and modernization of medical institutions. As the language of the authorizing legislation, its legislative history, and the overall structure of the program

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<http://www.ama-assn.org/ama1/pub/upload/mm/42/glbtpolicy0905.pdf>.

29. See generally Ethics Committee of the American Society for Reproductive Medicine, *Access to Fertility Treatment by Gays, Lesbians, and Unmarried Persons*, 86 FERTILITY & STERILITY 1333 (5th ed. Nov. 2006).

30. See generally *supra* note 8, at 564.

31. *N. Coast Women's Care Med. Group, Inc. v. Superior Court*, 189 P.3d 959, 963–65 (Cal. 2008).

32. Pub. L. No. 79-725, 60 Stat. 1041 (1946) (codified at 42 U.S.C. §§ 291–291m).

33. Peter D. Jacobson, *Health Law 2005: An Agenda*, 33 J.L. MED. & ETHICS 725 (2005).

34. *Id.*

demonstrate, Congress also intended that medical services be provided in areas where they were especially needed and under conditions designed to carry out specified congressional objectives.”<sup>35</sup> Those hospitals or other facilities who received federal funds under the Act were required to 1) make available the services provided to all persons within their territorial area and 2) provide a reasonable volume of services to persons unable to pay.<sup>36</sup> The first requirement is referred to as the “community service assurance,” and the second, the “uncompensated care assurance.”<sup>37</sup>

Hill-Burton was revised several times over the ensuing years.<sup>38</sup> In 1975, a revamped Hill-Burton Program,<sup>39</sup> codified as Title XVI of the Public Health Services Act, retained almost the exact community assurance requirement as its original Title VI counterpart, with one exception that broadened the coverage of persons to whom services would be made available. Programs originally funded under Title VI were required to provide services to all persons residing in the territorial area covered by the facility. Under the revised program, coverage was extended not only to residents, but “to all persons residing *or employed* in the area served by the facility.”<sup>40</sup>

The greatest concerns about and challenges to the Hill-Burton Program were focused more on the uncompensated care assurance rather than the community service requirement. One commentator said that “while the uncompensated service obligation has been a subject of controversy among the government, the hospital industry, and various consumer groups . . . the community service obligation prior to 1979 had been virtually ignored.”<sup>41</sup> Even a casual look at scholarly and other

35. Kenneth R. Wing, *The Community Service Obligation of Hill-Burton Health Facilities*, 23 B.C. L. REV. 577, 578 (1982) (providing an excellent and detailed legislative history of the Act).

36. 42 U.S.C. §§ 291c(e)(1)–(2) (2000) (amending prior section 291c, act July 1, 1944, ch. 373, ch. 373, title VI, § 613).

37. See Wing, *supra* note 35, at 578.

38. See Margaret Lynch Huddleston, *Due Process for Hill-Burton Assisted Facilities*, 32 VAND. L. REV. 1469, 1469–75 (1979) (describing the evolution of the Hill-Burton statute and regulations from its inception until 1979).

39. For purposes of this article, the revised program and the original program will both be referred to as “Hill-Burton.” See Pub. L. No. 79-725 § 622, 60 Stat. 1040 (1946).

40. 42 U.S.C. § 300s-1 (b)(1)(k) (2000) (emphasis added).

41. Wing, *supra* note 35, at 580; see also National Health Law Program, *A Hill-Burton Primer: Putting Flesh on the Bones of the Hill-Burton Community Service Regulations*, 19 CLEARINGHOUSE REV. 13 (1st ed. May 1985) (stating that “[M]ost



literature, as well as court opinions, shows that the community service obligation was definitely the poorer cousin to the free care requirement, receiving relatively little attention or comment.

By the 1970s, it appeared that while Hill-Burton had been successful in funding hospital construction,<sup>42</sup> it had been less successful in getting the recipients of its funds to live up to their community service or free-care obligations.<sup>43</sup> “Commentators generally are in agreement that, for nearly twenty-five years, enforcement of the Hill-Burton Act’s uncompensated care and community service assurances existed only in precatory, exhortative language.”<sup>44</sup> Throughout the 1970s, and culminating in 1979, the Department of Health and Human Services issued regulations, adding greater depth and showing more propensity for enforcement, especially of the heretofore ignored community service requirement.<sup>45</sup> The regulation adopted in 1979 states as follows:

In order to comply with its community service assurance, a facility shall make the services provided in the facility or portion thereof constructed, modernized, or converted with Federal assistance under Title VI or XVI of the Act available to all persons residing (and, in the case of facilities assisted under Title XVI of the Act, employed) in the facility’s service area *without discrimination on the ground of race, color, national origin, creed, or any other ground unrelated to an individual’s need for the service or the availability of the needed service in the facility.*<sup>46</sup>

There has been some, but little, litigation under the community service assurance provisions of the statute and

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health care advocates are familiar with the free care obligations. The community service requirements are less familiar.”).

42. “[F]rom 1946 to 1976, the Hill-Burton program supported the construction of 40% of hospital beds in the United States.” Peter D. Jacobsen, *Health Law 2005: An Agenda*, 33 J.L. MED & ETHICS 725, 732 (2005). See also James A. Morone, *The Health Care Bureaucracy: Small Changes, Big Consequences*, 18 J. HEALTH POL. POL’Y & L. 723 (Fall 1993). In the first thirty years of its existence, “Hill-Burton funds contributed to almost a third of [all] hospital construction projects in America.” *Id.* at 727.

43. Jacobson, *supra* note 33, at 732; *A Hill-Burton Primer*, *supra* note 4, at 13 (noting that “[n]o compliance standards were established [in the original act]; the result was that both obligations were virtually ignored for 25 years.”).

44. James F. Blumstein, *Court Action, Agency Reaction: The Hill-Burton Act as a Case Study*, 69 IOWA L. REV. 1227, 1238 (1984).

45. See 42 C.F.R. § 124.603(a)(1) (2008).

46. *Id.* (emphasis added).

pertinent regulations. The 1979 regulations were challenged generally in *American Hospital Association v. Schweiker*<sup>47</sup> as being beyond the scope of the statute. The court upheld the regulations, disputing the hospital association's contention that Hill-Burton was merely a construction statute with the community services assurance provision being incidental.<sup>48</sup> The court held that the requirement of providing services to individuals was an integral part of the statute, and that the Secretary had broad authority in enacting the regulations.<sup>49</sup> In *Wyoming Hospital Association v. Harris*,<sup>50</sup> the court also upheld the regulations, including those pertinent to the community service obligation. In this case, plaintiffs acknowledged that while the statute was intended to counter discrimination, they believed that the regulations were overbroad.<sup>51</sup> In particular, plaintiffs were troubled by part of the regulations that specified certain hospital policies that would run afoul of the community service provision.<sup>52</sup> Some of the examples included admissions policies that would preclude a large segment of the population, such as a requirement that would restrict admission to only those patients whose physicians had privileges to practice in the hospital.<sup>53</sup> Another example was a requirement for preadmission deposits.<sup>54</sup> The court disagreed with plaintiffs, holding that the community service obligation is not limited to traditional kinds of discrimination; it upheld the Secretary's power to issue the regulations.<sup>55</sup> In other cases, plaintiffs sought to flesh out what "all persons" meant in the language of the Act. In *Cook v. Ochsner Foundation Hospital*,<sup>56</sup> the court found that a hospital's exclusion (or sparing acceptance) of Medicaid patients resulted in violation of the community service assurance.

More recent post-1979 cases include *League of United Latin American Citizens v. Wilson*.<sup>57</sup> The case involved challenges to

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47. 721 F.2d 170 (7th Cir. 1983).

48. *Id.* at 176.

49. *Id.* at 178.

50. 727 F.2d 936 (10th Cir. 1984).

51. *Id.* at 938.

52. *Id.* at 940.

53. *Id.*

54. *Id.* at 939.

55. *Id.* at 940.

56. 61 F.R.D. 354 (E.D. La. 1972). This case was actually based on the statute and the 1972 regulations and is thought to be one of the catalysts to the revision of the regulations in 1979.

57. 908 F. Supp. 755 (C.D. Cal. 1995).

California Proposition 187, which required the denial of medical care and other government services to certain immigrants.<sup>58</sup> Plaintiffs argued that the state initiative was preempted by the Federal Constitution and other federal laws, including Hill-Burton.<sup>59</sup> Regarding the denial of healthcare benefits by public-funded healthcare facilities, the court regarded the “all persons” language of the statute, and the “any other ground” language of the regulations.<sup>60</sup> It held that “because Hill-Burton facilities must make their services available to all persons without regard to immigration status, the operation of section 6 [of Proposition 187] conflicts with the requirements of the Hill-Burton Act.”<sup>61</sup>

Finally, in *Aghazadeh v. Maine Medical Center*,<sup>62</sup> plaintiffs brought a claim under Hill-Burton for discrimination based upon language proficiency. Plaintiffs spoke little or no English, and the local hospital failed to provide interpreters, thereby functionally excluding a sizeable portion of persons in its territory.<sup>63</sup> The court held that the hospital had violated the community assurance requirement of the Hill-Burton Act.<sup>64</sup>

In enacting the 1979 regulations, comments to the regulations indicate a clarification, or broader view of persons “residing” in the covered territory. They define a person “residing” in an area as someone who: “(i) [i]s living in the service area with the intention to remain there permanently or for an indefinite period; (ii) [i]s living in the service area for purposes of employment; or (iii) [i]s living with a family member who resides in the service area.”<sup>65</sup> As well as adding the “employment” category as an alternate reason for inclusion, the comments note that it was intended, among other things, to bring migrant workers under the protection of the Act.<sup>66</sup>

Commentators on this anti-discrimination provision of Hill-Burton and its regulations have suggested that other kinds of discrimination fall within its purview. One commentator calls the

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58. *Id.*

59. *Id.* at 782.

60. *Id.*

61. *Id.* at 783.

62. No. 98-421-P-C., 1999 WL 33117182 (D. Me. June 8, 1999).

63. *Id.* at \*1.

64. *Id.* at \*9.

65. 42 C.F.R. § 124.603(a)(2) (2008).

66. Medical Facility Construction and Modernization; Requirements for Provision of Services to Persons Unable to Pay and Community Service by Assisted Health Facilities, 44 Fed. Reg. 29,399 (May 18, 1979).

community service provision “one of the clearest opportunities for courts to interpret legislation to reduce inequalities in access to health care services.”<sup>67</sup> Kenneth Wing states:

[A]s defined by the regulations, the community service obligation is far more than a proscription on discrimination in the usual sense of that term. Under the new regulations a hospital is required to accept virtually without exception anyone who is able to pay for medical services. Thus, people who do not have a physician on the facility’s medical staff; people who “probably can pay” but do not have cash, credit, or third party payment available; Medicaid and Medicare recipients; and at least by implication, the privately insured, would be assured access by the regulations.<sup>68</sup>

More specifically, another commentator states that the Office of Civil Rights (which is charged with enforcing Hill-Burton) “[h]as consistently taken the position that the community service obligation requires hospitals to address the needs of LEP [limited English proficiency] patients.”<sup>69</sup> Exclusion of AIDS patients from hospitals may violate Hill-Burton,<sup>70</sup> as may the refusal to treat undocumented aliens.<sup>71</sup> Hill-Burton bans discrimination based on

67. Jacobson, *supra* note 33, at 732. The author does despair, however, of the seeming invisibility of Hill-Burton as an effective tool when he laments that “in a 2000 volume devoted entirely to health inequality in the U.S., Hill-Burton is not even mentioned as a potential legal remedy.” *Id.*

68. Wing, *supra* note 35, at 581.

69. Jane Perkins, *Overcoming Language Barriers to Health Care*, 65 POPULAR GOV’T 38, 42 (1999), available at <http://www.sog.unc.edu/pubs/electronicversions/pg/f99-3844.pdf> (last visited Nov. 30, 2008) (citing U.S. DEP’T OF HEALTH & HUM. SERVS., GUIDE TO PLANNING THE HILL-BURTON COMMUNITY SERVICE COMPLIANCE REVIEW 16, 27 (1981)).

70. Ziyad I. Naccasha, *The Permissibility of Routine AIDS Testing in the Health Care Context*, 5 NOTRE DAME J.L. ETHICS & PUB. POL’Y 223, 251 n.172 (1990); Constance H. Baker & Megan M. Arthur, *AIDS in the Hospital Workplace: Theories of Hospital Liability*, 24 TORT & INS. L.J. 1, 6–7 (1988); Troyen A. Brennan, *Ensuring Adequate Health Care for the Sick: The Challenge of the Acquired Immunodeficiency Syndrome as an Occupational Disease*, 1988 DUKE L.J. 29, 36–37 (1988); Anne Bitton Gavzy & James V. Hetzel, *To Treat or Not to Treat: Healthcare Providers’ Duties*, 126 N.J. LAW. 52, 53 (1989).

71. Michael J. McKeefery, *A Call to Move Forward: Pushing Past the Unworkable Standard That Governs Undocumented Immigrants’ Access to Health Care Under Medicaid*, 10 J. HEALTH CARE L. & POL’Y 391, 397 (2007); Randall Kyle Hawes, *California Proposition 187: Will the Populist Mandate Survive Constitutional Scrutiny?*, 37 S. TEX. L. REV. 1391, 1406–07 (1996); Sana Loue, *Access to Health Care and the Undocumented Alien*, 13 J. LEGAL MED. 271, 282 (1992) (citing National Health Law Program, *A Hill-Burton Primer*, 19 CLEARINGHOUSE REV. 13, 17 (1985)); Peter L. Reich, *Public Benefits for Undocumented Aliens: State Law Into the Breach Once More*, 21 N.M. L. REV.

insurance status.<sup>72</sup> At least one scholar sees Hill-Burton as a viable claim in sex discrimination cases in healthcare contexts.<sup>73</sup>

#### IV. COMMUNITY SERVICE ASSURANCE: CAN IT BE APPLIED TO ART?

The National Women's Law Center has taken the position that discrimination in access to assisted reproductive services on the basis of marital status, sexual orientation, or other non-medical reasons constitutes a violation of the Hill-Burton Act.<sup>74</sup> Considering the *Benitez* case as an example, if North Coast were a recipient of Hill-Burton funds, would the community service obligation prohibit discrimination on the basis of sexual orientation or marital status? Can the community service provision be read to prohibit refusing ART services to any patient who can pay for the services?<sup>75</sup>

The plain meaning of the statute ("all persons") and, more explicitly, the regulations, say yes. The terms prohibiting the refusal of services—"or any other ground unrelated to the individual's need for the service"—is as open and inclusive as it could possibly be. Earlier in its history, there was some suggestion that the real purpose of the anti-discrimination language in Hill-Burton was to prevent racial discrimination only. This may be because of a one-time prohibition in the Hill-Burton statute that specifically mentioned race; the language was that "such hospital

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219, 233 n.88 (1991).

72. Alan Jenkins & Sabrineh Ardalan, *Positive Health: The Human Right to Health Care Under the New York State Constitution*, 35 FORDHAM URB. L.J. 479, 532 (2008); Sara Rosenbaum, *A Dose of Reality: Assessing the Federal Trade Commission/Department of Justice Report in an Uninsured, Undeserved, and Vulnerable Population Context*, 31 J. HEALTH POL. POL'Y & L. 657, 661 (2006).

73. Carol Jonann Bess, *Gender Bias in Health Care: A Life or Death Issue for Women With Coronary Artery Disease*, 6 HASTINGS WOMEN'S L.J. 41, 59–60 (1995).

74. Judith Waxman & Jill Morrison, *Letter to the Editor*, 89 FERTILITY & STERILITY 1032, 1032 (2008). Their position was met with neutrality by the editors, who stated that "we encountered a spectrum of reactions to the argument, from agreement to skepticism, regarding the applicability of the Act in this context." Robert Brzyski, *Reply of the Committee*, 89 FERTILITY & STERILITY 1032, 1033 (2008). This exchange was the inspiration for this article.

75. Ability to pay in this context is a tricky concept that requires that one keep separate the two Hill-Burton obligations. Under the community service requirement, the regulations state specifically that, except in an emergency, a facility may deny services to persons unable to pay for them. 42 C.F.R. § 124.603(a)(1) (2008). It adds, however: "unless those persons are required to be provided uncompensated services under the provisions of Subpart F [the uncompensated care assurance]." *Id.*

. . . will be made available to all persons residing in the territorial area of the applicant, without discrimination on account of race, creed, or color.”<sup>76</sup> There followed a separate-but-equal exception, a classic concept in the history of racial discrimination. And in fact, hospitals given Hill-Burton grants segregated patients according to race,<sup>77</sup> many of them in southern states.<sup>78</sup> This separate-but-equal exception was struck down by the Court of Appeals for the Fourth Circuit as unconstitutional.<sup>79</sup> This resulted in a change to the statute in 1964, which eliminated the separate-but-equal exception and specific references to racial and other kinds of discrimination. The new community services assurance read simply, “[T]he facility . . . will be made available to all persons residing in the territorial area of the applicant.”<sup>80</sup> Kenneth Wing concludes: “there can be no doubt that when Congress revised and recodified the authorizing legislation for Hill-Burton in 1964 it intended the program to impose a general community service requirement on recipient facilities, a requirement broader than a simple ban on racial discrimination.”<sup>81</sup> And again, “the prohibition of racial discrimination and conformance to the *Simkins* case was one major concern, but Congress rejected repeated and vocal suggestions to prohibit racial discrimination but not to require general availability.”<sup>82</sup>

Wing was writing in 1982. And while, as previously discussed, the community service assurance has not generated much litigation, that which exists before and after Wing’s observations can be fairly described as a broad interpretation of the “available to all persons” language. When agencies and courts determine that a statute provides for inclusion of racial minorities, immigrants,

76. Act of Aug. 13, 1946, 60 Stat. 1043 (amending Section 622(f) of the Hill-Burton Act).

77. Wing, *supra* note 35, at 601; see also P. Preston Reynolds, *Hospitals and Civil Rights, 1945–1963: The Case of Simkins v. Moses H. Cone Memorial Hospital*, 126 ANNALS OF INTERNAL MED. 898, 899 (1997).

78. Marianne Engelman Lado, *Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery*, 6 TEX. F. ON C.L. & C.R. 1, 19 (2001) (noting that “approximately ‘2,000 hospitals and medical facilities in 11 Southern states had received over one-half billion dollars for new construction under the Act’” (citation omitted) around the time of the *Simkins* case).

79. *Simkins v. Moses H. Cone Mem’l Hosp.*, 323 F.2d 959, 969 (4th Cir. 1963).

80. 42 U.S.C. § 291c(e) (1976).

81. Wing, *supra* note 35, at 602.

82. *Id.* at 607.

migrant workers, and persons with deficiencies in speaking English, and when commentators suggest that it covers AIDS patients, Medicaid and Medicare patients, undocumented aliens, and women, it is hardly a leap to include the unmarried and gay or lesbian individuals, as well as others, within the umbrella of statutory protection. At a minimum, given the broad language and purpose of the statute, the burden of proof and persuasion should fall on those who claim it is not applicable.

## V. OTHER POTENTIAL PROBLEMS IN APPLYING HILL-BURTON

### A. *The Hill-Burton Program is no longer active.*

Funding of hospitals and other medical facilities under Hill-Burton ceased in 1997.<sup>83</sup> As we move further away from that date, one must ascertain whether recipients of Hill-Burton monies retain any of the obligations that formed the conditions of their funding. While the uncompensated service provisions were to last twenty years from the date of completion of construction,<sup>84</sup> this limitation is not true of the community service assurance, at least as of 1979.<sup>85</sup> What this means is that while the passage of time may allow recipients to abandon the provision of free care, the obligation to provide service “to all persons” within the territory exists in perpetuity. Thus, for purposes of the anti-discrimination aspect of the Act, it does not matter when a facility received the funding; it matters only that the funding was in fact received.

83. U.S. Dep’t. of Health & Human Servs., Hill-Burton Free and Reduced Cost Health Care, <http://www.hrsa.gov/hillburton/default.htm> (last visited Nov. 30, 2008).

84. 42 C.F.R. § 124.501(b)(i) (2007). In some cases, the obligation to provide free care may extend beyond the twenty years if a facility does not provide sufficient service to remedy any deficit within the original twenty-year period. CONG. RESEARCH SERV., ORDER CODE 98-968, THE HILL-BURTON UNCOMPENSATED SERVICES PROGRAM 2-3 (2005), [https://www.policyarchive.org/bitstream/handle/10207/719/98-968\\_20050523.pdf](https://www.policyarchive.org/bitstream/handle/10207/719/98-968_20050523.pdf).

85. See 44 Fed. Reg. 29,397 (May 18, 1979); see also Wing, *supra* note 35, at 618 n.163 (explaining that there is no durational limit on the community service obligation as defined in the 1979 regulations). Earlier regulations may have placed a durational limit on the community service obligation, but the courts in *Cook v. Ochsner*, 61 F.R.D. 354 (E. D. La. 1972) and *Lugo v. Simon*, 426 F. Supp. 28 (N. D. Ohio 1976), found that the statute did not provide for such a limit. Huddleston, *supra* note 38, at 1473 n.39.

*B. An individual seeking services may not be within the territorial area served by the facility.*

The territory served by the facility is one that has been defined by the facility and accepted by the federal government in the facility's plan as the "service area."<sup>86</sup> An individual seeking medical care would have to reside in the area, or if the facility were funded under the newer Act, could either reside or be employed there.<sup>87</sup> Thus in any claim of discrimination, one would have to ascertain whether the prospective patient meets this criterion. While generally there are numerous facilities offering fertility services, that may not be true in some locations, such as rural areas where healthcare facilities of any kind are fewer. This may mean that in a given geographic area, there may be no facilities with a history of Hill-Burton funding.

*C. Identifying Hill-Burton facilities may be difficult.*

Perhaps because funding programs under Hill-Burton has ceased, it is difficult to discover up-to-date statistics about Hill-Burton facilities, including which entities received funds under the Act and when. The Department of Health and Human Services, Health Resources and Services Administration (HRSA) maintains a website that identifies Hill-Burton recipients; at present the website states that there are 218 obligated facilities.<sup>88</sup> Given the paucity of the number, this information refers only to those Hill-Burton recipients who still have obligations to provide free care, i.e., those for whom the applicable twenty years has not yet expired.<sup>89</sup> Because the community service obligation exists forever, any facility that received Hill-Burton funds at any time would still have to provide services "to all persons" within its service area.<sup>90</sup> In the

86. 42 C.F.R. § 124.602 (2007).

87. *See id.* § 124.603(a)(2)(i)–(ii).

88. U.S. Dep't. of Health & Human Servs., Hill-Burton Free and Reduced Cost Health Care, <http://www.hrsa.gov/hillburton/default.htm> (last visited Dec. 1, 2008).

89. *See id.*

90. *See* Medical Facility Construction and Modernization; Requirements for Provision of Services to Persons Unable to Pay and Community Service by Assisted Health Facilities, 44 Fed. Reg. 29,397 (May 18, 1979) (codified at 42 C.F.R. pt. 124).



absence of easily available information of all Hill-Burton funded entities (at least 7000 at the time of the 1979 regulations),<sup>91</sup> one seeking to challenge a refusal of services would have to request this information from the Department of Health and Human Services, or in informal or formal discovery in litigation against the facility.

*D. Some may mistakenly believe that Hill-Burton facilities are always located in a hospital and applicable only to inpatient care.*

Because the Hill-Burton program may have begun as a way to increase hospital facilities, and because of the early discourse surrounding Hill-Burton, one may draw an erroneous conclusion that hospitals, and in particular, inpatient services are the only services covered by the statute and regulations. The definition of a “facility” under Hill-Burton is “an entity that received assistance under Title VI or Title XVI of the Act and provided a community service assurance.”<sup>92</sup> In fact, Hill-Burton funds have been made available to many kinds of health-service entities, including hospitals, nursing homes, and outpatient and other healthcare facilities.<sup>93</sup> The agency comments to the 1979 regulations speak to the obligation of recipients to allocate their uncompensated services “in a manner most responsive to the needs of persons unable to pay,”<sup>94</sup> and give as examples that a facility might wish to concentrate on the provision of emergency services, or inpatient care, or outpatient clinic services.<sup>95</sup> Regarding fertility services, which are usually offered on an outpatient basis, and which may be offered within hospitals and in other, non-hospital settings, the form of the facility is not important. The only requirement is that it be a recipient of Hill-Burton funding.

91. *Id.* at 29,399 n.3; see Loue, *supra* note 71, at 281 (stating that one-half of the hospitals in the United States have received Hill-Burton funding). Loue’s sources, however, appear to be restricted to documents in the early and late 1970s, which means that the number could be much greater. See *id.* at n.66.

92. 42 C.F.R. § 124.602 (2007).

93. See CONG. RESEARCH SERV., *supra* note 84, at 1–2.

94. Medical Facility Construction and Modernization; Requirements for Provision of Services to Persons Unable to Pay and Community Service by Assisted Health Facilities, 44 Fed. Reg. 29,391 (May 18, 1979) (codified at 42 C.F.R. pt. 124).

95. *Id.*

*E. Conscience clauses allow providers to refuse some medical procedures.*

Perhaps the most formidable argument against the use of Hill-Burton when ART services have been refused is illustrated in the *Benitez* case, where the physicians (albeit unsuccessfully) claimed that providing the requested service to Ms. Benitez violated their religious beliefs.<sup>96</sup> There exist federal and state laws, so-called “conscience clauses,” that allow individual healthcare providers to refuse to perform certain medical procedures that offend their religious or moral convictions.<sup>97</sup> A full discussion of this issue is beyond the scope of this article. A brief look at conscience clauses and how they might or might not be used as a defense to claims under the anti-discrimination provisions of Hill-Burton, however, is appropriate.

The Church Amendment<sup>98</sup> was passed decades ago in 1973 shortly after the United States Supreme Court decision in *Roe v. Wade*.<sup>99</sup> It provided that any entity that received federal funds under any of several programs (including Hill-Burton) could not require any individual “to perform or assist in the performance of any sterilization procedure or abortion if his performance or assistance in the performance of such procedure or abortion would be contrary to his religious beliefs or moral convictions.”<sup>100</sup> It also stated that no entity could be forced to offer sterilization or abortion procedures if it were prohibited from doing so on the basis of religious beliefs or moral convictions.<sup>101</sup> More recently, Congress “put teeth into this insulation from government coercion in 2004 with the Weldon Amendment.”<sup>102</sup> It specified that no federal, state, or local government agencies or programs could

96. See *N. Coast Women’s Care Med. Group, Inc. v. San Diego County*, 189 P. 3d 959, 965–70 (Cal. 2008).

97. See, e.g., Martha S. Swartz, “Conscience” Clauses or “Unconscionable Clauses”: *Personal Beliefs Versus Professional Responsibilities*, 6 YALE J. HEALTH POL’Y L. & ETHICS 269, 271–73 (2006).

98. Pub. L. No. 93-45, § 401 (codified at 42 U.S.C. § 300a-7 (2000)).

99. 410 U.S. 113 (1973); see Wilson, *supra* note 27, at 47 (2008).

100. § 401(b)(1) (codified at 42 U.S.C. § 300a-7(b)(1) (2000)).

101. § 401(b)(2)(A) (codified at 42 U.S.C. § 300a-7(b)(2)(A) (2000)). This part of the statute was implicated in a claim under Hill-Burton in *Taylor v. St. Vincent’s Hosp.*, 369 F. Supp. 948 (D. Mont. 1973) (dissolving a prior injunction allowing a tubal ligation due to refusal by a Catholic hospital after the passage of the Church Amendment) *aff’d* 523 F. 2d 75 (9th Cir. 1975).

102. Wilson, *supra* note 27, at 49 (citing Consolidated Appropriations Act, 2005, Pub. L. No. 108-447, § 508(d)(1), 118 Stat. 2809, 3163 (2004); Act of Dec. 30, 2005, Pub. L. No. 109-149, § 508(d)(1), 119 Stat. 2833, 2879).

receive specified federal funds if they discriminated against a program that “does not provide, pay for, provide coverage of, or refer for abortions.”<sup>103</sup> The Danforth Amendment<sup>104</sup> and many state statutes echo the Church and Weldon Amendments, and in some cases, enlarge the meaning of abortion to include mere referrals for such services.<sup>105</sup>

Perhaps the most encompassing of the recent spate of conscience clause legislation is the recent federal rule entitled “Ensuring that Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law.”<sup>106</sup> This recent rule requires entities receiving federal funds to affirm their compliance with the Church and Weldon Amendments.<sup>107</sup> It also purports to include coverage for individuals “in the work force,” apart from physicians and other providers who engage in health care directly.<sup>108</sup> Examples given are surgical nurses and persons who clean instruments for certain medical procedures.<sup>109</sup> The broad reading of those who “assist in the performance”<sup>110</sup> of health services has led some to question whether secretaries who make appointments for abortion or abortion-related procedures could refuse to do so for reasons of conscience.<sup>111</sup>

Would such conscience clauses form a defense in a claim from a patient who has been denied fertility services? On the one hand, the federal legislation is specific to sterilization and abortion, or abortion-related, services. One could argue that ART is in fact the antithesis of sterilization and abortion procedures in that its purpose is to create life, rather than prevent or destroy it. On the other hand, there is a certain synchronicity of cultural values that might make bedfellows of those who oppose abortion and those who oppose ART, at least for some patients. This may mean that while there is no federal legislation of the Church Amendment

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103. Consolidated Appropriations Act § 508(d)(1); Act of Dec. 30, 2005 § 508(d)(1).

104. 42 U.S.C. § 238n (2000).

105. Wilson, *supra* note 27, at 48–49.

106. Provider Conscience Regulation, 73 Fed. Reg. 50,274 (Aug. 26, 2008) (to be codified at 45 C.F.R. pt. 88).

107. *See id.*

108. *Id.*

109. *Id.*

110. *Id.* at 50,275.

111. Hillary Rodham Clinton & Cecile Richards, *Blocking Care for Women*, N.Y. TIMES, Sept. 19, 2008, at A19.

variety pertinent to ART, there could be if the political will exists for its passage by Congress.

Turning to conscience clauses under state law, these are too numerous to detail. Suffice it to say, however, that some are not restricted to abortion and sterilization but to all kinds of medical procedures. One commentator says that “[l]egislation in Illinois, for example, provided refusal clause advocates with almost everything on their wish list. It protected health care personnel, institutions and payers from any form of liability or discrimination for refusing to perform almost any health care-related task against their conscience.”<sup>112</sup> Thus, an individual state’s law may be broad enough to include ART within its definition of medical services in which participation may be refused.<sup>113</sup> Interestingly, this same commentator compares state legislation in Mississippi, describing it as “topping Illinois’ as the country’s most expansive, providing seemingly all-encompassing lists of people and entities granted refusal rights, specific tasks they can refuse to perform and consequences from which they are immune.”<sup>114</sup> Mr. Sonfield continues to state that “[u]nlike Illinois’ law, it provides no exceptions for information or emergency care, instead only *prohibiting discrimination against patients on the basis of such characteristics as race, ethnicity, religion, sex, or sexual orientation.*”<sup>115</sup> Thus even in the most expansive state legislation (assuming this commentator is correct), there is attention paid to the need not to discriminate, at least on some enumerated bases.

There is another difference between most conscience clause legislation and the situations experienced by Ms. Benitez and other prospective patients. The conscience clause legislation defends the right of healthcare providers (however broadly or narrowly defined) from participation in certain *procedures*. For example, a doctor may refuse to provide abortion services if she is morally opposed. But that is different from concluding that the same doctor can participate in abortions or not, depending on the identity or characteristics of an individual patient. Presumably, the Church and Weldon Amendments would not shield a physician

112. Adam Sonfield, *Provider Refusal and Access to Reproductive Health Services: Approaching a New Balance*, GUTTMACHER POL’Y REV., Spring 2008, at 1, 2–3, available at <http://www.guttmacher.org/pubs/gpr/11/2/gpr110202.pdf>.

113. *Id.*

114. *Id.* at 4.

115. *Id.* (emphasis added).

who refused to perform abortions only on minority patients, or only on poor women, or who picked and chose abortion patients based upon any of a host of other social and/or economic considerations. Thus, even if the equivalent of the Church Amendment were passed with regard to ART services, it would protect the rights of those providers who didn't want to participate in the provision of *any* ART services, or maybe even particular ART services. (For example, a provider may have moral qualms only about surrogacy, and would refuse to participate in this procedure only.) It is difficult to imagine that the law would protect, or establish, a right of physicians and others to discriminate among patients seeking the same service.

Finally, conscience clauses cannot operate as "all-or-nothing, winner-take-all accommodations"<sup>116</sup> for providers who assert them. Rather, like all legally protected rights, they must balance the patient's need with the provider's rights to act in accordance with moral convictions. At least one commentator speaks of the need for—and growing recognition of—balance between patients' rights to reproduce (or simply to autonomy) and physicians' rights to refuse treatment.<sup>117</sup> As one example, Sonfield cites an opinion by the American College of Obstetricians and Gynecologists (ACOG) in which ACOG "put itself squarely in the middle of a simmering debate about health care providers' refusal to participate in sexual and reproductive health services."<sup>118</sup> The opinion by ACOG's ethics committee asserts that a right to refuse must be balanced by other factors and values of the medical profession, including a respect for patient autonomy and an intolerance of discrimination. This sort of balancing of rights is familiar territory in American jurisprudence. Ultimately, the existence of conscience clauses, broad in scope or more narrowly tailored to abortion-related services only, should not stand as an absolute barrier to claims of discrimination in access to care under Hill-Burton.

## VI. CONCLUSION

What we know about access to assisted reproductive technologies is that it is often limited to particular groups of persons, and is subject to the judgments of healthcare providers

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116. Wilson, *supra* note 27, at 45.

117. Sonfield, *supra* note 112, at 2.

118. *Id.*

concerning a patient's status, lifestyle, and other social and economic factors. Existing federal and state legislation does not always effectively constrain providers from refusing services to certain individuals.

The Hill-Burton Act, specifically its community service assurance, retains its vitality even after the discontinuance of the program and the waning of the number of hospitals who must comply with free service requirements. While little litigation exists concerning the community service provision, the language and history of the Act and its regulations call for a broad reading of the terms "all persons." The 1979 regulations in particular make clear that discrimination against prospective patients is forbidden if based on non-medical reasons. The use of Hill-Burton in cases involving refusal of ART services is certainly limited to those entities that have received Hill-Burton funding, and will apply only to those patients living within the designated service area. Conscience clause legislation or policies might conflict with claims under Hill-Burton. They would not in and of themselves invalidate those claims, but would at most, be balanced against a patient's need for medical services. In short, the vestiges and legacy of Hill-Burton—perhaps long forgotten and therefore deemed irrelevant—remain a viable tool for challenging discrimination in the provision of ART services.